



The MEDICAL EXAMINER



Industrial Medical Council

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QME NEWSLETTER

By: Dr. Susan McKenzie, M.D.

The Council is pleased to resume publication of *The Medical Examiner*, its QME newsletter that has been “on hiatus” since editor David Kizer was promoted to another position in state government. We miss David’s humor and editorial skills but look forward to working with our new editor, Suzanne Honor-Vangerov.

Sue is the IMC’s new Workers’ Compensation Manager. Her background as an Information and Assistance Officer and supervisor with the Division of Workers’ Compensation (DWC) and as a claims adjuster gives her a view of “the big picture” in workers’ compensation. Many of you may know her as a frequent speaker on medical billing and the *Official Medical Fee Schedule*.

I was appointed Executive Medical Director in April 2002, to replace Allan MacKenzie, M.D., who served the Council for over half of its history. Dr. MacKenzie’s shoes are hard to fill. He leaves an important legacy as a leader who shaped the Council’s image, completed its most sensitive mandates, and established strong collaborative working relationships with members of the workers’ compensation community.

As a physician who has served on the IMC staff since 1992, I have a historical perspective on the Council’s activities. This is one of the busiest seasons I can remember at the IMC. As in 1989 and 1993, workers’ compensation is targeted for legislative reform. Reform is tied to reduction of the state’s \$38 billion budget deficit and to shoring up the workers’ comp insurance industry that is suffering double-digit premium increases after deregulation. Employers, the Governor, and the legislature view reducing rising medical treatment costs in workers’ compensation as one way to accomplish this task.

Over fifty bills on workers’ compensation have been introduced in the Senate and Assembly. Governor Davis and Insurance Commissioner Garamendi are also offering proposals for reform. Medical fee schedules and control of utilization are the subject of several bills that are moving briskly through the legislature, although it is not possible now to assess the chances that these proposals will become law. A few of the bills are mentioned below and their full text can be accessed at <http://www.leginfo.ca.gov/bilinfo.html>.

Senate Bill 228, authored by Senator Richard Alarcon (Dem.), Chair of the Senate Industrial Relations Committee, would establish Medicare-based workers’ compensation fee schedules for medical treatment, ambulatory surgery centers, and pharmaceuticals. This bill provides that workers’ compensation fee schedules will be Medicare-based

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Quality of Medical-Legal Reports

By: Dr. Anne Searcy, MD

Complaints about the quality of medical-legal reports are common. However, when the complaints are dissected, they are usually about Treating Physicians’ Final Reports, rather than QME reports. Indeed, the quality of QME and AME reports has improved markedly over the years in which the Industrial Medical Council has reviewed reports. Nonetheless, there is always room for continued improvement as evidenced by the Council’s latest review of AME and QME reports.

The IMC staff uses a three tiered system to review the reports. All of the reports are inspected for the presence or absence of the required elements of a report according to La-

bor Code §4628 and 8 CCR 10606. All of the reports that are sent to the Council with a complaint and about 10% of the others are checked for the more complicated issues such as apportionment and whether the report complies with the Council’s evaluation protocols.

Take a look at these examples and see if they have a flaw. The answers are at the end of this article.

1. *Work Restrictions: None. She has returned to work.*

2. *Subjective Factors: Constant, slight pain in the left knee increasing with activity.*

3. *Subjective Factor: Frequent to constant, slight to moderate pain in both shoulders upon lifting over 20 lbs.*

4. *Grip on the right was 44 pounds and the left was 46. She is right hand dominant.*

Once again, in 2002, the most common finding was failure to note that the evaluator complied with the required face-to-face time. The evaluator can state the amount of time that was spent or simply that the requirement was met. It is important to note that face-to-face time is the time that the evaluator spends with the injured worker taking the history and doing the physical examination. It does not include the time spent filling out paperwork, getting an x-ray, or reviewing records.

Seventeen percent of the reports

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and that reimbursement for each CPT code will be capped at 120% of Medicare. New fee schedules would be created for ambulatory surgery centers and pharmaceuticals, while the OMFS would migrate directly to the Medicare Fee Schedule with a single conversion factor tied to Medicare's.

You may recall that the IMC was the first to undertake a number of studies to evaluate replacing the relative value scale in the OMFS with the methodology used in the resource-based relative value scale known as the RBRVS. The IMC has also proposed *adjusting* the RBRVS relative values for Evaluation and Management (E/M) codes to cover the unique services provided in workers' compensation.

In 2002, the IMC contracted with the Lewin Group to evaluate the long-standing perception among physicians that the physician work and office practice expenses for E/M codes in workers' compensation are greater than in other payment systems. Many of you participated in these studies.

Using accepted and rigorous methodology developed by the AMA and HCFA, the Lewin Group found that additional resources **are** required to provide E/M services such as management of disability and return-to-work. Lewin concluded that increasing RBRVS E/M values would make those values resource-based for workers' compensation, which would result in a 7% overall increase in reimbursement for medical treatment (from approximately 115% to 122-123% of 2003 Medicare). The Lewin studies also suggested transition strategies to minimize dislocations to physicians and disruptions to practice (access problems).

The OMFS is currently revised every two years by the Administrative Director of DWC. As the Alarcon bill moves through the Senate, DWC has posted its own draft revision of the OMFS on its website at <http://www.dir.ca.gov/dwc/DWCWCABForum/2.asp?ForumID=11>. This draft is based on the IMC's work and proposes the 7% increase in reimbursement suggested by the Lewin studies. This proposed increase would

compensate physicians for the additional work involved in workers' compensation E/M services without reducing the value of services performed under other CPT codes. DWC also requests suggestions for a transition strategy to phase-in changes to reimbursement and proposals for modifications to the ground rules. I urge you to look at the proposal and comment on the sections and policies relevant to your practice, either individually or through your associations.

Additional bills before the legislature deal with utilization (the number of medical services and visits provided). Senate Bill 757 (Poochigian - Rep.) would authorize the Administrative Director to create a utilization schedule based on a future study of utilization standards in other states. Senate Bill 354 (Speier-Dem.), supported by the Administration and Insurance Commissioner Garamendi, would impose both a system of utilization review by employers, and independent medical review (IMR) by entities who contract with the Administrative Director. The WCAB would no longer have jurisdiction to decide issues of extent and scope of medical treatment except on appeal from an IMR decision. Chiropractic and physical therapy would be limited to 15 visits unless approved by the employer or an IMR appeal. The IMR reviewer would not have to be licensed in CA, nor even be a physician. The treater presumption is abrogated on treatment issues, and a presumption is given to the IMR decision. *Both of these bills have passed the Senate and are to be heard in a conference committee.*

The Industrial Medical Council is planning to review utilization issues when it revises its nine medical treatment guidelines for common industrial injuries. One of the strengths of the IMC's guidelines lies in the fact that they are written for all physician groups that practice in the California Workers' Compensation System. Many of you participated in developing these guidelines. The task of revising them should be less daunting than creating them, and we may again ask you to share your expertise.

One final proposal deals with certifying treating physicians. Assembly Bill 1483, authored by Assembly members Keith Richman (Rep.) and Lynn Daucher (Rep.), would require all physicians who treat work-related injuries to be certified by the Industrial Medical Council in order to be paid. Certification would require taking a course, passing an examination, and completing 10 ratable reports. QMEs would be exempt from certification and certification would not be required if the physician did not participate in evaluation for workers' compensation benefits. All of the bills have passed one house of the legislature, have been "gutted" of their provisions, and will be heard in conference committee. Bills will likely be passed which contain major provisions of some of the current bills.

The QME Newsletter is again "on the street". We will use it to keep you informed about what's going on at the IMC and in the community. We welcome your comments and suggestions for topic and we plan to include articles from the community.

Newsletter Staff

Editor: Suzanne Honor-Vangerov, WCM

Associate Editor: Anne Searcy, MD

Layout & Design: Lety Buenviaje

Writers: Susan McKenzie, MD Richard Starkeson, Esq.

Anne Searcy, MD Lyndon Greco, DC, QME

James Fisher, Esq.

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*Correspondence should be directed to the Industrial Medical Council
P.O. Box 8888, San Francisco, CA 94128*

CHANGES IN LAW



AB 749 AND AB 486 NOW IN EFFECT

By: Richard Starkeson, Esq.

In this first major reform bill since the mid-nineties, the Legislature has made major changes to workers' compensation, most of which became effective January 1, 2003. There were also hundreds of minor changes. The first bill, AB 749, was signed into law in February 2002. There was also a trailer bill, AB 486, which made minor corrections and additions, which also became law on January 1, 2003. The most significant changes are increases in permanent and temporary disability rates and increases in death benefits. There are also other changes, which have special importance to physicians and the Industrial Medical Council.

Here is a list of the major changes:

- ◆ Repeals the current presumption of correctness of the treating physician
- ◆ Provides for a second QME evaluation if an unrepresented worker hires an attorney after his panel QME report. Also allows the employer to obtain a second QME evaluation if the employee does.
- ◆ Requires employers to provide the IMC Panel RequestForm when they make the last payment of temporary disability.
- ◆ Repeals "baseball arbitration."
- ◆ Requires the Administrative Director, in consultation with the IMC, to develop educational materials for treating physicians.
- ◆ Provides for the Administrative Director to adopt fee schedules for pharmaceuticals and outpatient surgery.
- ◆ Requires pharmacies to provide generic drugs, unless the physician has directed otherwise.
- ◆ Allows workers to settle rehabilitation rights, if they have an attorney.
- ◆ Provides a statute of limitations for liens for medical treatment and medical-legal costs.
- ◆ Includes a follow-up visit within the definition of "First-aid".
- ◆ Requires the Administrative Director, in consultation with the IMC, to conduct a study of medical treatment provided to injured workers.
- ◆ Requires the Administrative Director to adopt regulations to require health care providers to use standardized forms for medical bills.
- ◆ Requires the Administrative Director to adopt regulations to require employers to accept medical bills in electronic form.
- ◆ Creates the position of Court Administrator, to manage the judges and procedures of W.C.A.B. offices, and to develop ethics rules for judges.

Benefits

Indemnity benefits are increase over a period of years, ending in 2006. Thereafter, there is a built in escalator clause, based on the "State Average Weekly Wage (the average wage that California employers pay employees covered by unemployment insurance). In addition, the number of weeks of permanent disability per per-

centage point of rating, will increase for some parts of the scale.

Temporary Disability

There is a minimum benefit again, of \$126 per week. Maximum for 2003 is \$602; for 2005, is \$840.

Permanent Disability

The minimum increases to \$100 for 2003, to \$130 for 2006. Maximum is \$230 in 2003; \$270 in 2006

Death Benefits

One dependent, total or partial, \$125,000 in 2003. Up to \$320,000 for 3 total dependents in 2006.

Life Pensions

For injuries of 70% or greater permanent disability, the benefits will increase substantially, because the "life pension" that is payable for such injuries, has a large increase.

Presumption of correctness of the treating physician

For most cases, this presumption is now abolished. It remains, however, if the employee had designated a physician in writing to his employer before the injury. Note however, that, as before, the predesignated physician has to have "previously directed the medical treatment of the employee," and have retained the employee's medical records, including a medical history. There is no presumption if both the employee and the employer obtain QME reports.

Outpatient Surgery Facility Fee Schedule

AB 486 provided for the Administrative Director to develop and promulgate an Outpatient Surgery Facility Fee Schedule. However, the bill required the use of certain data that would not be obtainable for over a year. Probably as a result of these requirements, this year's SB 228, introduced by the democrat chair of the Senate Labor And Industrial Relations Committee, provides that if the fee schedule is not adopted by January 1, 2004 (which all agree it is not possible to do), that these fees will be limited to Medicare reimbursement rates (initially, but after a new fee schedule is adopted, to be limited to 120% of Medicare rates). SB 228 would also abolish the Official Medical Fee Schedule, and tie all physician fees to Medicare rates (or Medi-Cal, if there were no identical Medicare procedure.)

Pharmaceutical fee schedule

The Administrative Director is also required to develop a fee schedule for Pharmaceuticals, by July 1, 2004. However, this provision would also be subject to this session's SB 228, which would tie pharmacy fees to Medicare rates.

Second QME evaluation

An employee who did not have an attorney when he had a QME evaluation, and who later hires an attorney, can now have a second QME evaluation. If he does, the employer could also obtain another QME evaluation. All the reports would be admissible in evidence.

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HIPAA AND WORKERS' COMPENSATION IN CALIFORNIA

By: James Fisher, Esq.

Recently, physicians, and other health care providers, have questioned how the Health Insurance Portability and Accountability Act (HIPAA) affects the medical treatment and reporting requirements of the California workers' compensation system. This is a legitimate question because HIPAA purports to provide a national comprehensive privacy protections of patients protected health information (PHI) would impact the reporting requirements inherent in the California workers' compensation system.

Congress never intended HIPAA to restrict the flow of medical information required by state workers' compensation systems. When it passed HIPAA, the Congress defined workers' compensation benefits as an "excepted benefit", or a benefit not covered by HIPAA. On April 14, 2003, the Department of Health and Human Services (HHS) issued the final HIPAA Privacy rule. HHS is the federal agency charged with issuing and enforcing the regulations implementing HIPAA. HHS implemented Congress' intent, by expressly exempting the disclosure of PHI in workers' compensation cases. The Privacy rule also indirectly allows the disclosure of PHI in workers' compensation cases through other exemptions to the Privacy rule. The rules that exempt disclosures from the Privacy rule are the workers' compensation exception, the required under state law exception, the payment exception, and the exception for disclosures for judicial and administrative proceedings. I will briefly mention the exceptions and briefly discuss their relevance to the California workers' compensation system. When discussing the HIPAA exceptions, the language used in the act and their definitions is very important. In HIPAA, physicians and other health care providers collectively fall under the definition of "covered entities", or an entity covered by the privacy provisions of HIPAA.

Disclosures permitted without patient authorization

Three situations allow the release

of PHI without a release signed by the patient and do not provide for a mechanism for the patient to forbid the disclosure of the PHI. 45 CFR §164.522 (a)(1)(v). These situations are:

• The Workers' Compensation Exemption

The workers' compensation exemption authorizes "a covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault." 45 CFR §164.512(l)

• Disclosures required by State or other laws

This exceptions states "a covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law." 45 CFR §164.512(a).

• Disclosures required for payment

This exception allows for disclosure of PHI "pursuant to and in compliance with a consent that complies with §164.506, to carry out treatment, payment, or health care operations." 45 CFR §164.502(a)(1)(ii) and the definition of "payment" at 45 CFR §164.501.

How these exceptions to HIPAA work in the California Workers' Compensation System

The central issues when determining the scope of any disclosure of medical information are the claimed disabilities and the defenses raised to the claimed disabilities, including theories for reducing liability, for example apportionment, raised by the defense. The exceptions to patient authorization, mentioned above, cover the vast majority of medical disclosures in most workers' compensation matters. There is substantial overlap between the workers' compensation exemption and the disclosures required by law. The disclosures required by payment provision allows for the dis-

closure of PHI as required under Labor Code §4603.2. The workers' compensation or the required by law exemptions allow for the disclosure of medical information in Doctors' First Report of Injury; the reports of treating physicians under section 9795 of the Administrative Director's rule; and, medical legal reports under Labor Code §§4060, 4061 and 4062.

Disclosures for judicial and administrative proceedings

A "covered entity" may disclose protected health information in the course of any judicial or administrative proceeding in two circumstances. 45 CFR §164.512(e). First, in response to an order of a court or administrative tribunal, the covered entity may disclose only the protected health information expressly authorized in the order. The second situation, commonly found in workers' compensation cases, is the production of PHI in response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative body. In this situation, a covered entity may release of information if four conditions are met:

➤ The covered entity receives "satisfactory assurance" from the party seeking the information that reasonable efforts have made to inform the individual that their PHI is being requested.

➤ The notice contains sufficient information about the judicial proceeding for the individual to raise an objection to the disclosure of the PHI.

➤ The time for the individual to raise objections to the court or administrative tribunal has elapsed.

➤ The disclosure of PHI can proceed if there are no objections to the disclosure of the information or if any objections are raised have been made has been resolved.

In this context, "satisfactory assurance" does not mean that the individual actually know that their PHI is being sought. The rule only requires the party requesting the information that a good faith attempt to provide written notice to the individual.

In a worker's compensation case,

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PROTECT YOURSELF FROM LAWSUIT AND PENALTIES

By: Richard Starkeson, Esq.

Physicians should be reminded that the completion of the Doctor's First Report of Injury is **mandatory** for **every** injury, no matter how slight. There is a common belief that no Doctors' First Report needs to be filed for an injury for which only "first aid" is given. This belief is incorrect. Some employers have pressured physicians not to prepare Doctors' First Reports for minor injuries, in order that their insurance rates remain low. This conduct is illegal both for the employer and the physician who cooperates. Don't let yourself be put in the embarrassing posi-

tion of having to explain why you did not file a Doctor's First for an injury. The Department of Insurance, in cooperation with the Los Angeles District Attorney, recently prosecuted a claim against the largest industrial medical provider in California, U.S. Healthworks and Alternative Solutions, Inc. for not filing these forms. U.S. Healthworks agreed to a \$900,000 civil penalty. The Doctor's First Report is to be filed with the insurance carrier or self-insured employer, who are required to forward them to the Department of Industrial Relations.

If your office cannot obtain insurance information from the employer, document your file of your attempts to obtain the information. Question (1) of the form, **Insurer Name and Address**, should be filled out, **"Employer refused to furnish this information."** Send the form to the employer; give the worker a copy; and keep a copy for your records. To protect yourself, you send a copy with answer to Question (1) highlighted in color to:

**CA Department of Insurance
Fraud Division
PO Box 277320
Sacramento, CA 95827-7320**

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Death Benefits go to estate, if no dependents

As of January 1, 2004, if an employee dies as a result of a work injury and has no dependents, the death benefit (\$250,000) will be payable to the employee's estate. Up until now, they have been payable to the Death Without Dependents Fund, which funds the Subsequent Injuries Fund. In the past, this has provided a substantial portion of the funding. It remains to be seen where SIF will get its funding. It is also possible that this provision will be held to be unconstitutional, based on the concept that the state Constitution provides for workers' compensation system for employees and their dependents. (The estate not being a dependant).

Treating physicians

The Administrative Director, in consultation with the IMC, is to develop educational materials for treating physicians and chiropractors, to give them information and training in basic concepts of workers' compensation, the role of the treating physician, the conduct of permanent and stationary evaluations, and report writing. These materials are to be ready by January 1, 2004.

Lien claims for med-legal expenses

There is now a statute of limitation for filing these lien claims. They must be filed within 6 months of a final decision on the employee's claim, 5 years after the date of injury, or 1 year from the date services were provided, whichever is later. There is an exception for providers that furnished medial treatment on a non-industrial basis. They may file a claim within 6 months of their learning that an industrial injury is being claimed.

Claims administrators to furnish IMC panel request form

Claims administrators are now required to send to employees not represented by an attorney, the IMC Panel Request Form, along with the last payment of temporary disability indemnity. This may speed the process of panel QME evaluations for unrepresented employees.

Penalties

In an attempt to put limits on penalties, Labor Code § 5814 was amended to prevent multiple penalties being awarded for the same type of delayed benefit, unless there was a legally significant event between the initial delay and subsequent delays. It is unclear how this would apply to penalties for delay in payment for medical treatment, if the employer had provided no treatment at all. The new question of when there is a "legally significant event" would have to be litigated before the W.C.A.B. However, SB 457, now being considered in the legislature, would again completely revamp the treatment of penalties.

Disclosure of medical information

This bill would permit disclosure to an employer of the mental or physical condition for which workers' compensation is claimed and the treatment provided for this condition. Specifically, the administrator or insurer could disclose "the diagnosis of the mental or physical condition for which the compensation is claimed, and treatment provided for this condition. Presumably, a pre-existing condition that might affect the healing process would not be disclosed unless it was a part of the current claim.

Rehabilitation can now be settled

Employees can now settle rehabilitation rights in all case, but only if they are represented by an attorney. The settlement would be limited to \$10,000, although the amount of rehabilitation benefits, if not settled, is limited to \$16,000.

First aid includes follow-up visit

Labor Code §5401 is amended to redefine *first aid* as "any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, or other minor industrial injury, which do not ordinarily require medical care. This one-time treatment, and follow-up visit for the purpose of observation, is considered first aid even though provided by a physician or registered professional personnel".

IAIABC 89th Annual Convention

September 2 - 6, 2003

San Francisco Marriott, San Francisco, California

A variety of workers' compensation related medical topics including:

- ▶ Workers' Compensation Medical: Quality, Costs, Access, and Delivery
- ▶ Training and Education for Workers' Compensation Specialists
- ▶ Impact of HIPAA 2003 Regulations on State Workers' Compensation Privacy Laws
- ▶ Pharmaceutical Use Patterns in Workers' Compensation

For more information go to the IAIABC web site:

www.iaiaabc.com or call 608-663-6355

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were obviously not served in a timely manner. For reports after 1993, the evaluator has 30 days to submit the report. A 30-day extension can be requested if test results or a consulting physician report has not been received. A 15-day extension can be requested if there is a medical emergency of the evaluator or the evaluator's family, there is a death in the evaluator's family, or there is a natural disaster or other community disaster. If the medical records are late in arriving, the evaluator should issue the report and do a supplemental later, as necessary.

Either the county or date where the report was signed was not included in eleven percent of the reports. The name and qualification of a person who assisted the physician was not properly identified in nine percent of the reports. Certified interpreters should be used in the preparation of medical reports involving languages for which they are available.

Internal inconsistencies are found in twenty three percent of the "problem" reports. For instance, the injured worker has severe pain when lifting over twenty pounds but there is no lifting work preclusion. Another common mistake found in these reports is writing the work preclusion for the present job rather than the open labor market.

Most of the reports fall under the Neuromusculoskeletal Evaluation Guidelines. Twenty percent of

the reports did not have a complete physical examination. For instance, upper extremity injuries must include girth of the limbs and grip strength documented three times per side. Also, tests such as x-rays are commonly ordered, but the reason for the test is incorrectly omitted. It is important not to perform unnecessary tests and to delineate the reason for a test in each case.

In summary, QME and AME reports have shown significant improvement over the last decade. Many of the mistakes are simple ones that could be corrected by using a checklist as that found in the Physician's Guide on page 103. Some of these easily corrected omissions are considered serious enough to make the entire report inadmissible. Others go to the weight that a report is given in court. It is also important that the report be internally consistent.

Answers:

1. *This work restriction is not written for the open labor market and doesn't indicate whether she is back to her usual and customary occupation.*

2. *What activity causes the pain to increase and to what level?*

3. *There is no flaw. It is acceptable to signify when the severity or frequency falls between two levels.*

4. *Grip must be recorded 3 times on each side. It is also necessary to estimate the normal grip for bilateral injuries.*

Cont'd from page 4 -- HIPAA ...

the parties, specifically the defense, acquire medical records using a special subpoena, known as a consumer records subpoena. Evidence Code sections 1985.3 and 1985.4. In California, a consumer records subpoena appears to meet the requirements of HIPAA. A word of warning about medical records subpoenas: never produce the records before the time to object to the subpoena has lapsed. Premature production of medical records is the road to unnecessary legal complications.

The minimum necessary limitation on disclosure

HIPAA generally restricts the disclosure of PHI to the "minimum necessary" to comply with a request or demand for information. HIPAA defines the "minimum necessary" as "the minimum necessary to accomplish the intended purpose of the use, disclosure, or request." 45 CFR §164.502(b). The "minimum necessary" does not apply to:

- Disclosures to or requests by a health care provider for treatment.
- Uses or disclosures made pursuant to an individual's authorization.
- Uses or disclosures that are required by other law.

The rules also allows "cover entities" to rely on the representations of third parties that the information requested is the "minimum necessary" for the intended use. These categories are:

- A public official or agency who states that the information requested is the minimum necessary for a purpose permitted under 45 CFR §164.512 of the Rule.

The workers' compensation exception requires "covered entities" limit disclosure "to the minimum necessary to accomplish the workers' compensation purpose." The HIPAA measure of what PHI is the "minimum necessary" is circular because disclosure depends on the requirements of the state workers' compensation law.

In conclusion, there is no basis for HIPAA hysteria. It appears that QME's can maintain the vast majority of their current reporting practices and not conflict with HIPAA.

IMPORTANT NOTICE TO ALL QMEs AND DR's OFFICE STAFF

A number of QME offices serve upon the Industrial Medical Council the following forms:

- ◆ Form 110-QME Appointment Notification Form;
- ◆ Form 111-Qualified or Agreed Medical Evaluator's Findings Summary Form;
- ◆ DEU Form-101-Request For Summary Rating Determination;
- ◆ DEU-Form 100-Employee's Permanent Disability Questionnaire;
- ◆ Completed Reports of the QME Evaluation;
- ◆ Supplemental Reports;
- ◆ Billing and Statement of Charges and/or Lien Forms

PLEASE NOTE

**DO NOT SERVE ANY OF THE ABOVE-MENTIONED FORMS ON THE IMC.
SERVE THEM AS SHOWN BELOW.**

FORMS	WHERE TO SERVE
IMC FORM 110: QME Appointment Notification	➡ On the <i>Employee</i> , and ➡ On the <i>Worker's Comp. Insurer/Administrator or Self-insured Employer</i> .
IMC FORM 111: Qualified or Agreed Medical Evaluator's Finding Summary Form DEU FORM 101: Request For Summary Rating Determination DEU FORM 100: Employee's Permanent Disability Questionnaire Completed QME Permanent Disability Reports Supplemental Reports Billing & Statement Of Charges/Lien Forms	<p><i>IF THE EMPLOYEE IS UNREPRESENTED, SERVE ALL OF THE FORMS LISTED ON THE LEFT SIDE AS FOLLOWS:</i></p> ➡ On the <i>Disability Evaluation Unit</i> district office ➡ On the <i>Employee</i> , and ➡ On the <i>Worker's Comp. Insurer/Administrator or Self-insured Employer</i> . <p><i>IF THE EMPLOYEE IS REPRESENTED BY A LAWYER, SERVE ALL LISTED FORMS</i></p> ➡ On the <i>PARTY OR PARTIES</i> who requested the evaluation only.

◆ Copies of forms can also be downloaded from the: ◆
 IMC Website: www.dir.ca.gov/imc & DWC Website: www.dir.ca.gov/dwc

CHIROPRACTIC MEDICAL NECESSITY

Lyndon Greco, DC QME

AN INTRODUCTION TO THE PART GUIDELINES

The following article is the opinion of the author and is not to be construed as policy put forward by the IMC. It is intended for informational purposes only. The IMC and the Division of Workers' Compensation have not adopted the PART guidelines for documenting medical necessity for chiropractic care under workers' compensation in California.

PART is an acronym used to document Chiropractic physical examination findings for the Federal Medicare program. Its components are defined as Pain/Tenderness; Asymmetry/Misalignment; Range of Motion Abnormality; and Tissue tone, Texture, Temperature abnormality. By using the **PART** criteria as a foundation it is hoped that this article will illuminate some of the dark areas of confusion that often exist between the Chiropractic profession and those not familiar with our methods.

In particular this article will explore when Chiropractic Manipulative Treatment (CMT) is medically indicated. In doing so the **PART** guidelines as developed by the federal government for Chiropractic Medicare providers are presented. Documentation of **PART** criteria is required nationally for reimbursement under the Medicare system in most circumstances. Its guidelines therefore come closest to presenting a national standard for the indication of Chiropractic treatment. Exploration of its concepts and also its consequences will help shed some understanding on the profession and its procedures.

Firstly, the origin of the inter-professional confusion surrounding Chiropractic care is well understood. Many look at the profession in dismay as we apply practically identical procedures to a broad variety of differing conditions. Chiropractors will regularly use their treatment methods for everything from discogenic back pain to a facet syndrome; a radiculopathy to a sprained lumbar fascia. The application of manipulation fits all and those outside of the realm of manual therapy are often perplexed. How could one apply manipulation and its adjunctive therapies to such a variety different conditions? After all there are many diagnoses, but only one focused treatment approach.

The answer to these queries lays in how the typical Doctor of Chiropractic (DC) approaches the clinical encounter. The DC will be looking to identify and rule-in a mechanical lesion in the spine; at the same time they are using their skills of differential diagnosis to refine this diagnosis and also rule-out any inappropriate candidates for their therapies. A chiropractic lesion may have many symptomatic and pathological manifestations. Thus there is the appearance of a wide variety of diagnoses that may be treated. However, the common thread woven through these diagnoses is the identification of a mechanical component to these ailments.

Many practitioners of manual therapy have named these mechanical lesions. Doctors of Osteopathy may call them "somatic lesions". The term "joint dysfunction" is popular among the rare Doctors of Medicine and Physical Therapists who are familiar with the manual therapy approach. Many in the circles of Chiropractic also will

use this term as well when identifying a mechanical lesion. However the profession as a whole prefers the term "subluxation" when noting the lesion in question. Unfortunately this sows seeds of confusion as our colleagues in Orthopedic Surgery define a subluxation as a partial dislocation. They would view manual therapy and CMT as contraindicated in this situation. Nonetheless, when a Doctor of Chiropractic identifies a subluxation its definition is *not* "partial dislocation" but instead is a mechanical lesion amendable to their care. The synonym to remember is that subluxation equals a Chiropractic mechanical lesion.

Now let us further consider what this lesion *is not* before diving further into its findings and indications. Firstly, DC's are taught to thoroughly screen their patients for the presence of the proverbial Red Flags that would necessitate an immediate referral and/or contraindicate their care. Information is also gained at this stage as to the nature of pathology that may certainly influence the application of Chiropractic care and its therapies.

These patients emerge as initial candidates for Chiropractic care following this triage. The point at this juncture is that the indication for Chiropractic care is not yet assured. In other words the absence of the Red Flags does not in itself indicate subluxation-the Chiropractic mechanical lesion.

The next step is to rule in the presence of the Chiropractic mechanical lesion. This is where the guidelines come in. The **PART** guidelines grew out of the Balanced Budget Act of 1997, which required replacing the previously mandated radiographic documentation of subluxation/mechanical lesion for Medicare with documentation based upon the physical examination.

The American Chiropractic Association, the nation's largest Chiropractic organization, commissioned the Lewin Group to convene a blue ribbon panel of experts to develop guidelines for the diagnosis of subluxation. (Of interest to the Worker's Compensation community is that this is the same Lewin Group responsible for research into the new upcoming fee schedule.) **PART** resulted from this consensus panel. In January of 2000, they were implemented by Medicare.

Also of interest is that historically the **PART** analysis may be traced back to the medical profession. Its formative criteria were first mentioned in the third edition of the noted text *Spinal Manipulation* by two Canadians, an Orthopedic Surgeon named JF Bourdillon and EA Day a Physical Medicine and Rehabilitation specialist. This was published in 1987.

PART as noted is an acronym and at this juncture let us discuss its components and some examples:

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“P” – Pain/Tenderness: pain and tenderness may be identified by various methods including provocation, palpation, observation and so on. Location, quality, and intensity are also noted. Documentation via functional questionnaire is also appropriate.

“A” – Asymmetry/Misalignment: Postural and gait observation may be used for gross misalignment; static palpation may be employed for identification of the more subtle vertebral misalignment.

“R” – Range of Motion Abnormality: Visualizations, motion palpation, and diagnostic measurements may be employed to note changes in active, passive, and accessory joint motion and mobility.

“T” – Tissue tone, Texture, Temperature Abnormality: Palpation, observation, strength & length testing, and instrumentation may be used to note changes in contiguous soft tissue such as skin, fascia, muscle, and ligament.

In implementing the **PART** criteria one must have at least two of the above four components to document the subluxation/mechanical dysfunction with one of them being either “A” or “R”. Observation of this criteria rules in the Chiropractic assessment of a mechanical lesion, and subsequently satisfies the physical exam requirement for medical necessity of Chiropractic Manipulative Treatment in Medicare.

Implicit in the **PART** criteria is a system of combining multiple evaluative approaches for a synergistic effect. This is often known as an examination “cluster” and is used throughout healthcare. For example an Internist’s auscultation of the Heart in itself may be some what unreliable and imprecise. However when their evaluation is clustered with other diagnostic studies (lab-work, EKG, etc.) the evaluation becomes more precise and profound. The same phenomena is at work within **PART**. The often maligned and unreliable palpatory findings of Chiropractic evaluation are combined with one another and other criteria for a more valuable resulting assessment. The provider is therefore more assured of the presence of the mechanical lesion.

In looking at the **PART** criteria one is struck by its very conservative model of care. The results of invasive, complicated, and often expensive modes of assessment are not required to proceed forward with treatment. Granted these are used in refining the diagnosis and the techniques of care; however a Doctor of Chiropractic will often rely on their palpation and other physical exam skills alone to care for their patients.

In regards to the California Workers’ Compensation system one should note that components of the **PART** criteria are well suited to the factors used in patient assessment. Loss of range-of-motion and subjective reports of pain are important in both the Chiropractic assessment and when rating permanent disability. The system is sensitive to these issues as are the practitioners of Chiropractic.

Consequently, one should also note that the Workers’ Compensation system gives legitimacy to the lesions often encountered by the Chiropractic profession. Most practitioners are familiar with the profoundly injured worker without very marked findings on imaging and other forms of diagnostic testing. However these patients may have a very remarkable physical examination using the criteria of **PART**. One could argue that the Chiropractic physical examination with its unique skills and assessment may be more sensitive to these problems.

In general one also notes that the indications for Chiropractic treatment are also very broad when using the criteria as presented. As noted previously, pain or some other complaint in and of itself does not indicate a necessity for Chiropractic care. Neither does the absence of the classic red flags alone give the de facto green light for care. **PART** notes that a provider must rule-in the presence of a mechanical lesion/subluxation before care is indicated.

Nonetheless, in spite of this defined indication for Chiropractic care, reflection reveals that the criteria are in fact very broad. With hallmark findings such as pain, range-of-motion abnormalities, and a host of palpatory signs, the population in-

dicated for Chiropractic care is large.

This opens up a proverbial Pandora’s box of issues for the profession and its patients. In particular with broad indications for treatment how does one define the end points of care? A well-intentioned Doctor of Chiropractic may find patients they could treat indefinitely along the lines of **PART**, or similar criteria.

A national Chiropractic organization, The Council on Chiropractic Practice published guidelines entitled *Vertebral Subluxation in Chiropractic Practice* that encapsulates this perspective. In their chapter on the duration of care they recommend:

“Since the duration of care for correction of vertebral subluxation is patient specific, frequency of visits should be based upon the reduction and eventual resolution of indicators of vertebral subluxation”.

Several other guidelines offer differing perspectives and recommendations regarding the endpoints of care with the resulting dialectic addressing this issue. Practitioners constantly balance the mechanical indications for their care (a la **PART**) with the response and functionality of the patient. Symptom relief is important; improvement in specific activity intolerance and work worthiness are important; physiological and biomechanical markers are important. Not unlike other providers within the health care system multiple factors are used to balance a complete program of care.

In summary, the typical Doctor of Chiropractic begins the clinical encounter with a triage of care designed to rule-out clinical contraindication. The following steps include ruling in care and refining its applications. The **PART** guidelines as we noted are an accepted example of the “rule-in” criteria indicating care. With the weight of the Federal government behind **PART** it may approach the status as *the* national standard for the indication of Chiropractic care. Finally, in this context of care patient treatment ensues according to these criteria and the entire interplay of responses, goals of care, accepted standards & guidelines, and ultimately the professional judgment of the Doctor of Chiropractic.

Editorial

By: Suzanne Honor-Vangerov
Workers' Compensation Manager

In this time of focus on the problems with workers' compensation in California, I thought I'd take this opportunity to discuss the IMC's role in all of the proposed reforms. The IMC is a regulatory agency. We receive our mandates from the state legislature, which writes the statutory laws that spell out what our program contains. We then develop the regulations that support and implement the program setting forth how it functions on a day to day basis. In that capacity, it is our responsibility to regulate several areas that involve delivery of medical services to injured workers within California.

The most well known portion of this function is the Qualified Medical Evaluator (QME) program within the workers' compensation system. In addition to the QME program we also act in an advisory capacity to the Department of Industrial Relations, Division of Workers' Compensation in a variety of areas including treatment and evaluation guidelines, medical fee schedules and medical reporting forms.

Recently we have received a number of communications from the public asking what the IMC intends to do about a number of legislative issues affecting the provision of medical services to injured workers - cre-

ating the medical fee schedules, setting treatment and utilization guidelines, etc. If members of the public wish to communicate their concerns about the reforms that are being proposed we have the following suggestions:

◆ For concerns about proposed legislation, contact the state legislator who is sponsoring the bill. For current bill information go to <http://www.leginfo.ca.gov>. Contact information for state assemblymembers is available at <http://www.assembly.ca.gov>, for state senators it's <http://www.sen.ca.gov>.

◆ For concerns about policies being set by the Division of Workers' Compensation send an e-mail to the division at dwc@dir.ca.gov or write to P.O. Box 420603, San Francisco, CA 94142. You can also view proposed regulations and other items of interest at their web site at <http://www.dir.ca.gov/dwc>.

◆ You should also contact any professional organization with which you are affiliated and express your concerns. Most of these organizations employ lobbyists who bring the concerns of the membership to the state legislature and the Administrative Director of the Division of Workers' Compensation.



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QME Exam Notice



The next exam is September 20, 2003. The cutoff date to receive applications is postmarked no later than August 21, 2003. Beginning with this exam, there will be a \$125.00 non-refundable fee to sit for the exam. If you need an application or have any other questions, please call at 1-800-794-6900.

Industrial Medical Council

The following providers have been approved by the Industrial Medical Council for Continuing Education Courses

***P**lease contact individual providers for upcoming scheduled classes and specific information about the course.
The IMC retains copies of all courses which are available for inspection at the IMC offices.*

**** Denotes at home class option ****

100**	California Orthopaedic Association (COA) (916) 454-9884	380	AF ICC (661) 861-1000	730	Professional Psych Seminars (805) 371-9443
110**	California Chiropractic Association (CCA) (916) 648-2727 ext.125	410	Michael M. Bronshvag, M.D., Inc. Neuro-Musculo-Skeletal System (209) 478-0504	740	University of California - Davis (916) 734-53934
120**	David W. O'Brien Attorney at Law (949) 363-0684	420	University of California-Berkeley Center For Occupational & Environmental-Health (510) 643-7277	800**	California Workers' Compensation Enquirer (CWCE) (800) 446-0070
140**	California Society of Industrial Medicine & Surgery (CSIMS) (916) 446-4199	450	California Society of PM & R (702) 365-0912	830	James T. Platto, M.P.H, DC (209) 966-5652
160	California Applicants Attorneys' Association (CAAA) (916) 444-5155	470**	Livingstone-Lopez Consulting (760) 944-6769	850	Current Compensation Seminars (415) 399-9769
210	Los Angeles College of Chiropractic Post Graduate Division (562) 902-3379	520	Insurance Educational Association (IEA) (800) 655-4432	870	Innecalm Associates Post Graduate Department (800) 551-0755
230	Division of Workers' Compensation (415) 703-4600	560	Saint Francis Memorial Hospital (415) 353-6000	880	American Institute of Acupuncture Ortho & Traumatology (415) 731-6683
270	International Chiropractors Association of California (ICAC) (916) 362-8816	570	Dean Falltrick, D.C. (530) 269-1128	890	Northern CA Neuro-psychology Forum (510) 236-5599
310	CompRite (949) 581-7063	580**	Industrial Medicine Seminar (650) 619-3111	920	Workers' Compensation Seminar (310) 271-8300
330	American Academy Of Disability Evaluating Physicians (800) 456-6095	640	Palmer College of Chiropractic (800)452-5032	930	CA Workers' Compensation Defense Attorneys' (916) 484-4354
340	Western Occupational Health Conference (WOHC) (415) 927-5736	670**	State Compensation Insurance Fund (415) 565-3184	970	Los Angeles County Podiatric Medical Society (800) 654-3338
360	Northbay Workers' Compensation Association (707) 575-6725	690	American College of Chiropractic Orthopedists (ACCO) (541) 757-1396	980	Martin J. Morris, MD (714) 544-7683
		720	California Acupuncture Medical Association (818) 710-1566	990	Webility (508) 358-5218
				1000	SouthBay Industrial Claims Association (408) 378-9195

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